

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/23/2015
NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS		STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint #IN00182108.</p> <p>Complaint #IN00182108 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>September 23, 2015</p> <p>Facility number: 000104 Provider number : 155197 AIM number: 100266590</p> <p>Census payor type: Medicaid: 18 Other: 93 Total: 111</p> <p>Sample: 4</p> <p>Sanctuary at St. Pauls was found to be in compliance with 410 IAC 16.2-5 in regards to the Investigation of Complaint IN00182108.</p> <p>QR was completed by 99993 on 09/25/15.</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE